Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 9/27/10
Amount 1770.00

Christian Care Communities, Inc.
#49041

I. IDENTIFICATION

Name: Christian Health Center

Address: 920 South 4th Street

City/County/Zip: Louisville / Jefferson / 40203

Telephone number: (502) 583-6533

Administrator: Raymond A. Dickison, Jr.

RECEIVED
SEP 27 2010
OFFICE OF INSPECTOR GENERAL

Date facility operation began at current address: 1984

Date facility began operation under current owner: 1984

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home	4	4
✱ Nursing Facility	118	118
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	(Nonprofit)	Partnership
City		(Corporation)
(Private)		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Christian Care Communities, Inc.
12710 Towne Park Way
Louisville, KY 40243

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Christian Care Communities, Inc.

Address of corporation 12710 Towne Park Way, Louisville, KY 40243

President or Chairman Dr. Keith Knapp

Vice President Mr. Rick Marshall

Secretary N/A

Treasurer Mr. Nick Harshfield

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Kayad A Rt — Executive Director — 9/19/10

Signature of authorized representative | Title | Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)